COMMUNITY HEALTH
& WELLNESS PARTNERS
Care... To Live Life Fully

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Patient Legal Name First MI Last

Preferred Name: ______________ Date of Birth: ________ Social Security # __________________

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Address City: State: Zip Code:

Home Phone: _____________________ Mobile Phone: ___________________

Email: ______________________________ Preferred Way of Contact: Phone Email Text

Marital Status: _______________

Emergency Contact: __________________ Phone Number: __________ Relationship: ___________

Race: _____________ Ethnicity: ______________ Sex at Birth: Male or Female

Sexual Orientation: _________ Gender Identity: __________ Transgender Male or Female: _______

Preferred Language:
____English ____Spanish____ French ____German ____Russian ___Other ___Sign Language

Homeless: Yes or No - If yes, where are you living? ___________________

Foster Child: Yes or No - If yes, please provide all proper paperwork prior to scheduling)

Do you need assistance with transportation? Yes____No_____ Do you have assisted devices? ________

Are you a Veteran? Yes_____No_____ Are you a Migrate Worker? Yes_____ No___

<u>INSURANCE INFORMATION</u>

Primary Insurance: ___________________________ Policy Holder: ________________________

Relationship to Patient: ______________ Copay: _________

ID Number: _______________________ Group Number: _______________

Secondary Insurance: _______________________________________
Please Provider ALL insurance cards at the time of visit or email to billinginfo@chwplc.org

Revised: 2/2024